Department of State Health Services
Council Agenda Memo for State Health Services Council
January 29, 2009

Agenda Item Title: New rule concerning the requirements for stroke facility designation

Agenda Number: 5b

Recommended Council Action:

_____ For Discussion Only

__X__ For Discussion and Action by the Council

Background: Currently the Office of EMS/Trauma Systems (OEMS/TS) in the Division for Regulatory Services provides a regulatory program that designates trauma facilities for the state to decrease morbidity and mortality from trauma related patient injuries to the citizens of Texas. OEMS/TS will provide the same regulatory program for Stroke Facility Designation. Since the Stroke Facility Designation rules have not been adopted or implemented yet, OEMS/TS does not currently regulate any facilities for this program. It is expected that initially when the rules are adopted there will be approximately 25 healthcare facilities that will apply for stroke facility designation. No appropriation of funds exists for the implementation of the Stroke Facility Designation program. The application fee of $100 is the only source of funds for this program.

Summary: The purpose of the new rule is to establish a framework for the development of a voluntary statewide emergency treatment system for stroke victims. Such a system will allow stroke victims to be rapidly identified and then transported to and treated in appropriate stroke treatment facilities. The new rule will allow for the development of an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease and stroke in the state.

The new rule is necessary to comply with Senate Bill 330, 79th Legislature, Regular Session, 2005 (Codified in Health and Safety Code, Sections 773.204 and 773.205), which requires the Governor's Emergency Medical Services (EMS) and Trauma Advisory Council (GETAC), with the assistance of its Stroke Committee and in collaboration with the Texas Council on Cardiovascular Disease and Stroke (TCCDS), to develop stroke facility criteria and a statewide stroke emergency transport plan; and Acts, 2003, 78th Legislature, Regular Session, Chapter 198, (House Bill 2292), Section 2.42, added Health and Safety Code, Section 12.0111, which requires DSHS to charge a fee sufficient to cover the cost of administering and enforcing the stroke designation program.

The new rule describes how hospitals will qualify for stroke facility designation after they have been accredited by the Joint Commission and how the 22 regional advisory councils (RACs) may develop regional stroke system plans to include stroke emergency transport plans that must include:

- Training requirements on stroke recognition and treatment, including emergency screening procedures;
- A list of appropriate early treatments to stabilize patients;
- Protocols for rapid transport to a stroke facility when rapid transport is appropriate and it is safe to bypass another health care facility;
- Plans for coordination with statewide agencies or committees on programs for stroke prevention and community education regarding stroke and stroke emergency transport; and
- A $100 nonrefundable application fee for each hospital seeking stroke designation.

Summary of Input from Stakeholder Groups:

The draft rules were presented for review at the November 2007 GETAC meeting and were reviewed by the Stroke Committee, which is comprised of representatives from hospitals, nurses, physicians, EMS providers, and RACs. The Stroke Committee suggested changes that were incorporated into the rule regarding stroke system planning and stroke system development per RAC requirements.

The rule was presented to GETAC at its February 2008 and May 2008 meetings for additional discussion. Changes to the rule from these meetings included adding additional language regarding hospitals reporting non-compliance with stroke criteria to providers and DSHS, reducing the length of designation from three years to two years to match the Joint Commission accreditation, and other minor clarifications. The proposed rule was again reviewed by GETAC at its August 16, 2008, meeting where they approved a motion for the rule to move forward to the State Health Services Council.

At its November 22, 2008, meeting, the Stroke Committee approved the proposed rule with the addition of the Stroke Facility Criteria for Level III designation. GETAC also approved the proposed rule with the addition, and recommended that the rule move forward to the State Health Services Council.

Proposed Motion: Motion to recommend HHSC approval for publication of rule contained in agenda item **#5b**

Approved by Assistant Commissioner/Director:	Kathryn C. Perkins, RN, MBA			**Date:**	12/18/08
Presenter:	Jane Guerrero	**Program:**	Office of EMS/Trauma Systems Coordination	**Phone No.:**	834-6745
Approved by CPCPI:	Carolyn Bivens			**Date:**	12/18/08

Title 25. Health Services
Part 1. Department of State Health Services
Chapter 157. Emergency Medical Care
Subchapter G. Emergency Medical Services Trauma Systems
New §157.133.

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission on behalf of the Department of State Health Services (department) proposes new §157.133, concerning the requirements for stroke facility designation.

BACKGROUND AND PURPOSE

The proposed rule is necessary to comply with Senate Bill 330, 79th Legislature, 2005, Regular Session, that amended Health and Safety Code, §773.204 and §773.205, which requires the Governor's Emergency Medical Services (EMS) and Trauma Advisory Council (GETAC), with the assistance of its Stroke Committee and in collaboration with the Texas Council on Cardiovascular Disease and Stroke (TCCDS), to develop stroke facility criteria and a statewide stroke emergency transport plan; and Acts, 2003, 78th Legislature, Regular Session, Chapter 198, (House Bill 2292), §2.42, added Health and Safety Code, §12.0111, which requires the department to charge a fee sufficient to cover the cost of administering and enforcing the stroke designation program.

SECTION-BY-SECTION SUMMARY

The proposed rule describes how hospitals will qualify for stroke facility designation after they have been accredited by the Joint Commission and how the 22 regional advisory councils may develop regional stroke system plans to include stroke emergency transport plans that must include: (1) training requirements on stroke recognition and treatment, including emergency screening procedures; (2) a list of appropriate early treatments to stabilize patients; (3) protocols for rapid transport to a stroke facility when rapid transport is appropriate and it is safe to bypass another health care facility; (4) plans for coordination with statewide agencies or committees on programs for stroke prevention and community education regarding stroke and stroke emergency transport; and (5) a $100 nonrefundable application fee for each hospital seeking stroke designation.

FISCAL NOTE

Renee Clack, Section Director, Health Care Quality Section, has determined that for each year of the first five years that the section will be in effect, there may be an increase in revenue to state government. Since stroke designation is a voluntary process, it cannot be determined which year will have an increase in revenue because it depends upon when the stroke facilities will seek the stroke facility designation. The department estimates that 25 stroke facilities will seek stroke facility designation lasting for a period of two years. The 25 facilities will have to pay a $100

fee to redesignate every two years which will be an increase to the state. Existing resources within the department will be utilized to process and review applications, provide technical assistance, and recommend designation to the Commissioner.

There will be no fiscal implication to local governments as a result of enforcing or administering the section as proposed unless a local government operates a healthcare facility and voluntarily chooses to seek stroke designation. In that case, the local government will be required to comply with the rule and submit a $100 nonrefundable application fee. Once the rule is adopted, a local government that voluntarily seeks stroke facility designation will incur costs to become accredited by the Joint Commission. The cost associated with these proposed requirements, other than the $100 application fee, cannot be determined since the local market in which the local government resides will determine the fiscal impact on each healthcare facility.

MICRO-BUSINESS AND SMALL BUSINESS ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

Ms. Clack has also determined that the number of healthcare facilities meeting the definition of a micro-business would likely be very low, but there could be a number of healthcare facilities meeting the definition of a small business. There will be no fiscal impact on micro-businesses and small businesses or persons unless they operate a healthcare facility and voluntarily choose to seek stroke designation. In that case, the micro-businesses and small businesses or persons will be required to comply with the rule and submit a $100 application fee. Once the rule is adopted, a micro-business or small business that seeks stroke facility designation will incur costs to become accredited by the Joint Commission. The cost associated with the proposed requirements, other than the $100 application fee, cannot be determined since the local market in which the small businesses or micro-businesses resides will determine the fiscal impact on each healthcare facility. Since the seeking of a stroke facility designation from the department would be a voluntary endeavor and not a requirement, there would be no fiscal impact to healthcare facilities, not seeking designation, and therefore a regulatory flexibility analysis is not required. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

In addition, Ms. Clack has also determined that for each year of the first five years the section is in effect, the public will benefit from adoption of the section. The public benefit anticipated as a result of enforcing or administering the section is to construct a statewide emergency treatment system so that stroke victims may be rapidly identified and then transported to and treated in appropriate stroke treatment facilities. The proposed rule will allow for the development of an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of cardiovascular disease and stroke in the state.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from

environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed new rule does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Jane Guerrero, Office of EMS/Trauma Systems Coordination, Health Care Quality Section, Division of Regulatory Services, Department of State Health Services, P. O. Box 149347, Austin, Texas 78714-9347, (512) 834-6700 or by email to jane.guerrero@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rule has been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The proposed new rule is authorized by Health and Safety Code, Chapter 773, Emergency Medical Services, which provides the department with the authority to adopt rules to implement the Emergency Medical Services Act; Health and Safety Code, §12.0111, which requires the department to charge a fee sufficient to cover the cost of administering and enforcing the stroke designation program; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

The proposed new rule affects Health and Safety Code, Chapters 12, 773, and 1001; and Government Code, Chapter 531.

Legend: (Proposed New Rule)
Regular Print = Proposed new language

§157.133. Requirements for Stroke Facility Designation.

(a) The Office of Emergency Medical Services (EMS)/Trauma Systems Coordination (office) shall recommend to the Commissioner of the department (commissioner) the designation of an applicant/healthcare facility (facility) as a stroke facility at the level(s) for each location of a facility the office deems appropriate.

(1) Comprehensive Stroke Facility designation, Level I--The facility, including a free-standing children's facility, meets the current Brain Attack Coalition essential criteria for an accredited comprehensive stroke center; actively participates on the appropriate Regional Advisory Council (RAC); and submits data to the department as requested.

(2) Primary Stroke Facility designation, Level II--The facility, including a free-standing children's facility, meets the current Brain Attack Coalition essential criteria for an accredited primary stroke center; actively participates on the appropriate RAC; and submits data to the department as requested.

(3) Support Stroke Facility designation, Level III--The facility, including a free-standing children's facility, meets essential criteria (in the attached graphic) for an accredited support stroke facility; actively participates on the appropriate RAC; and submits data to the department as requested.

Figure: 25 TAC §157.133(a)(3)

(b) A healthcare facility is defined under these rules as a single location where inpatients receive hospital services or each location if there are multiple buildings where inpatients receive hospital services and are covered under a single hospital license. Each location shall be considered separately for designation.

(c) The designation process shall consist of three phases.

(1) First phase. The application phase begins with submitting to the office a timely and sufficient application for designation as a stroke facility and ends when the survey report is received by the office.

(2) Second phase. The review phase begins with the office's review of the survey report and ends with its recommendation to the commissioner whether or not to designate the facility.

(3) Third phase. The final phase begins with the commissioner reviewing the recommendation and ends with his/her final decision.

(d) Designation of a healthcare facility as a stroke facility is valid for two years.

(e) It shall be necessary to repeat the stroke designation process as described in this section prior to expiration of a facility’s designation or the designation expires.

(f) A timely and sufficient application for a facility seeking initial designation shall include:

(1) the department's current "Complete Application" for the requested level of stroke facility designation, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office;

(2) full payment of the non-refundable $100 designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the office;

(4) a stroke designation survey completed within one year of the date of the receipt of the application by the office; and

(5) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office.

(g) If a healthcare facility seeking initial designation fails to meet the requirements in subsection (f)(1) - (5) of this section, the application shall be denied.

(h) A timely and sufficient application for a stroke facility seeking redesignation shall include:

(1) the department's current "Complete Application" form for the requested level of stroke facility designation, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office one year or greater before the designation expiration date;

(2) full payment of the non-refundable $100 designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the office; and

(4) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office no less than 60 days prior to the designation expiration date.

(i) If a healthcare facility seeking redesignation fails to meet the requirements outlined in subsection (h)(1) - (4) of this section, the original designation will expire on its expiration date.

(j) The office's analysis of the submitted "Complete Application" form may result in recommendations for corrective action when deficiencies are noted and shall also include a review of:

(1) evidence of current participation in RAC/regional system planning; and

(2) the completeness and appropriateness of the application materials submitted, including the submission of a non-refundable application fee of $100.

(k) Facilities seeking Comprehensive, Primary or Support stroke facility designation shall request a survey through The Joint Commission’s stroke certification program or a comparable organization approved by the department.

(l) A designated stroke facility shall:

(1) comply with the provisions within this rule, all current state and regional stroke system standards as described in this chapter, and all policies, protocols, and procedures as set forth in the state stroke system plan; and

(2) continue to provide the resources, personnel, equipment, and response as required by its designation level.

(m) Designated stroke facilities failing to meet and/or maintain critical essential criteria outlined in this subsection, shall provide notification about such failings within five days to the office, its RAC, plus other affected RACs, EMS providers, and the healthcare facilities from which it receives and to which it transfers stroke patients:

(1) neurosurgery capabilities (Level I);

(2) neurointerventional surgery capabilities (Level I);

(3) neurology capabilities (Level I, II);

(4) anesthesiology (Levels I);

(5) emergency physicians (all levels);

(6) stroke medical director (all levels);

(7) stroke nurse coordinator/program manager (all levels); and

(8) stroke registry (all levels).

(n) If the facility chooses to apply for a lower level of stroke designation, it may do so at any time; however, it may be necessary to repeat the designation process. There shall be a paper review by the office to determine if and when a full survey shall be required.

(o) If the facility chooses to relinquish or change its stroke designation, it shall provide at least 30 days notice to the RAC and the office.

(p) A healthcare facility may not use the terms "stroke facility", "stroke hospital", "stroke center", “comprehensive stroke center”, “primary stroke center”, “support stroke facility” or similar terminology in its signs or advertisements or in the printed materials and information it provides to the public unless the healthcare facility is currently designated as that level of stroke facility according to the process described in this section.

(q) The office may review, inspect, evaluate, and audit all stroke patient records, stroke performance improvement, committee minutes, and other documents relevant to stroke care in any designated stroke facility or applicant/healthcare facility at any time to verify compliance with the statute and this rule, including the designation criteria.

(r) If a designated stroke facility fails to meet and/or maintain standards, outlined herein, or if it violates the department hospital licensing regulations, the department may deny, suspend or revoke the designation.

(s) A RAC should develop a stroke system plan based on standard guidelines for comprehensive system development. The stroke system plan is subject to review and approval by the department.

(t) The department may review the RAC’s stroke system plan to assure that:

(1) all counties within the trauma service area (TSA) have been included unless a specific county, or portion thereof, has been aligned within an adjacent system;

(2) all health care entities and interested specialty centers have been given an opportunity to participate in the planning process; and

(3) the following components have been addressed:

(A) stroke prevention;

(B) access to the system;

(C) communications;

(D) medical oversight;

(E) pre-hospital triage criteria;

(F) diversion policies;

(G) bypass protocols - guidelines for the emergency transport of patients, who are eligible within the timeframe for United States Food and Drug Administration (FDA) approved stroke care therapies, to the highest state designated stroke center;

(H) regional medical control;

(I) regional stroke treatment guidelines:

(i) guidelines consistent with current standards shall be developed, implemented, and evaluated;

(ii) individual agencies and medical directors may, and are encouraged, to exceed the minimum standards;

(iii) stroke patients will be cared for by health professionals with documented education and skill in the assessment and care of stroke throughout their pre-hospital and hospital course;

(iv) stroke patients will have their medical care, as documented by pre-hospital run forms and hospital charts, reviewed by the individual entity's medical director for appropriateness and quality of care; and

(v) stroke patients will have deviations from standard of care addressed through a documented stroke performance improvement process.

(J) facility triage criteria;

(K) inter-hospital transfers;

(L) planning for the designation of stroke facilities, including the identification of the comprehensive, primary, and support stroke facilities; and

(M) a performance improvement program that evaluates processes and outcomes from a system perspective.

(u) Department approval of the completed stroke system plan may qualify health care entities participating in the system to receive state funding for stroke care if funding is available.

Figure: 25 TAC §157.33(a)(3)

Support (Level III) Stroke Facility Criteria

Support (Level III) Stroke Facilities (SSFs) - Provides resuscitation, stabilization and assessment of the stroke victim and either provides the treatment or arranges for immediate transfer to a higher level of stroke care either a Comprehensive (Level I) Stroke Center or Primary (Level II) Stroke Center; provides ongoing educational opportunities in stroke related topics for health care professionals and the public; and implements stroke prevention programs.

A. Stroke Program	
1. Identified Stroke Medical Director who: a. Is actively credentialed by the hospital to provide stroke care b. Is charged with overall management of the stroke care provided by the hospital c. Shall have the authority and responsibility of clinical oversight of the stroke program. This is accomplished through mechanisms that may include, but are not limited to: credentialing of staff that provide stroke care; providing stroke care; development of treatment protocols; cooperating with nursing administration to support the nursing needs of the stroke patient; coordinating the performance improvement peer review; and correcting deficiencies in stroke care. i. There shall be a defined job description ii. There shall be an organizational chart delineating the Stroke Medical Director's role and responsibility iii. The Stroke Medical Director shall be credentialed by the hospital to participate in the stabilization and treatment of stroke patients using criteria such as board-certification/board eligibility; stroke continuing medical education; compliance with stroke protocols, and participation in the Stroke Process Improvement (PI) program. d. The Stroke Medical Director shall participate in a leadership role in the hospital and community.	**E**
2. Identified Stroke Nurse Coordinator who: a. Is a Registered Nurse b. Has successfully completed and is current in Advanced Cardiac Life Support c. Has successfully completed 8 hours of stroke continuing education in the last 12 months d. Has successfully completed National Institutes of Health Stroke Scale (NIHSS) by an approved certification program or a DSHS (Department of State Health Services) approved equivalent e. Has the authority and responsibility to monitor the stroke patient care from Emergency Department (ED) admission through stabilization and transfer to a higher level of care or admission i. There shall be a defined job description ii. There shall be an organizational chart delineating roles and responsibilities iii. The Stroke Nurse Coordinator shall have a minimum of 8 hours of continuing education per 12 months. iv. The Stroke Nurse Coordinator shall be current in NIHSS certification v. The Stroke Nurse Coordinator shall receive education and training designed for his/her role which provides essential information on the structure, process, organization and administrative responsibilities of a PI program to include stroke outcomes and performance improvement	**E**

Figure: 25 TAC §157.33(a)(3)

Support (Level III) Stroke Facility Criteria

3. An identified Stroke Registrar who: a. Has appropriate training in stroke chart abstraction b. Has appropriate training in stroke registry data entry c. Has the ability to provide stroke registry data to the PI program	**D**
4. Written protocols, developed with approval by the hospital's medical staff: a. Stroke Team Activation b. Identification of stroke team responsibilities during the stabilization of a stroke patient c. Triage, admission and transfer criteria of stroke pts. d. Protocols for the administration of thrombolytics and other approved stroke treatments e. Stabilization and treatment of stroke patients f. Facility capability for stroke patients will be provided to the Regional Advisory Council	**E**
B. PHYSICIAN SERVICES	
1. Emergency Medicine – this requirement may be fulfilled by a physician credentialed by the hospital to provide emergency medical services a. Any emergency physician who provides care to the stroke patient must be credentialed by the Stroke Medical Director to participate in the stabilization and treatment of stroke patients (i.e. current board certification/eligibility, compliance with stroke protocols and participation in the stroke PI program). b. An average of 8 hours per year of stroke related continuing medical education c. An Emergency Medicine Physician providing stroke coverage must be current in Advanced Cardiac Life Support (ACLS). d. The emergency physician representative to the multidisciplinary committee that provides stroke coverage to the facility shall attend 50% or greater of multidisciplinary and peer review stroke committee meetings.	**E**
2. Radiology - Capability to have computerized topography (CT) report read within 45 minutes of patient arrival	**E**
3. Primary Care Physician – the patient's primary care physician should be notified at an appropriate time.	**D**
C. NURSING SERVICES (all patient care areas)	
1. All nurses caring for stroke patients throughout the continuum of care have ongoing documented knowledge and skills in stroke nursing for patients of all ages to include: a. Stroke specific orientation b. Annual competencies c. Continuing annual education	**E**
2. Written standards on nursing care for the stroke patients for all units caring for stroke patients shall be implemented	**E**
3. 100% of nurses providing initial stabilization care for stroke patients shall be competent in: a. NIHSS (competency or certification) b. Dysphagia screening c. Thrombolytic therapy administration	**E**
D. EMERGENCY DEPARTMENT	
1. The published physician on-call schedule must be available in the Emergency Department (ED).	**E**
2. A physician with special competence in the care of the stroke patient who is on-call (if not in-house 24/7) shall be promptly available within 30 minutes of request from outside the hospital and on patient arrival from inside the hospital.	**E**
3. The physician on duty or on-call to the ED shall be activated on EMS communication with the ED or after a primary assessment of patients who arrive to the ED by private	**E**

Figure: 25 TAC §157.33(a)(3)

Support (Level III) Stroke Facility Criteria

vehicle **or** for patients who are exhibiting signs and symptoms of an acute stroke.	
4. A minimum of one and preferably two registered nurses who have stroke training shall participate in the initial stabilization of the stroke patient. Nursing staff required for initial stabilization is based on patient acuity and "last known well time". 5. 100% of the nursing staff have successfully completed and hold current credentials and competencies in: a. ACLS (certification) b. NIHSS (competency or certification) c. Dysphagia Screening (competency) d. Thrombolytic therapy administration (competency)	**E**
6. Nursing documentation for stroke patients is systematic and meets stroke registry guidelines.	**E**
7. Two-way communication with all pre-hospital emergency medical services.	**E**
8. Equipment and services for the evaluation and stabilization of, and to provide life support for, critically ill stroke patients of all ages shall include, but not limited to: a. Airway control and ventilation equipment b. Continuous cardiac monitoring c. Mechanical ventilator d. Pulse oximetry e. Suction devices f. Electrocardiograph-oscilloscope-defibrillator g. Supraglottic airway management device h. All standard intravenous fluids and administration devices i. Drugs and supplies necessary to provide thrombolytic therapy	**E**
E. RADIOLOGICAL CAPABILITY	
1. 24-hour coverage by in-house technician	
2. Computerized tomography	**E**
F. CLINICAL LABORATORY SERVICE	
1. 24-hour coverage by in-house lab technician	**D**
2. Drug and alcohol screening	**D**
3. Call-back process for stroke patients within 30 minutes 4. Bedside glucose 5. Standard analyses of blood, urine and other body fluids, including micro-sampling 6. Blood typing and cross-matching 7. Coagulation studies 8. Blood gases and pH determination	**E**
G. PERFORMANCE IMPROVEMENT	
1. A facility must show at least 6 months worth of audits for all qualifying stroke patients with evidence of "loop closure" on identified issues. 2. Minimum inclusion criteria: a. All stroke activations b. All stroke admissions c. All transfers out d. All readmissions e. All stroke deaths	**E**
3. An organized Stroke PI program established by the hospital a. Audit charts for appropriateness of stroke care	**E**
b. Documented evidence of identification of all deviations from standards of stroke care c. Documentation of actions taken to address identified issues d. Documented evidence of participation by the Stroke Medical Director e. Morbidity and mortality review including decisions by the Stroke Medical	**E**

Figure: 25 TAC §157.33(a)(3)

Support (Level III) Stroke Facility Criteria

Director as to whether or not standard of care was met f. Documented resolutions "loop closure" of all identified issues to prevent future reoccurrences g. Special audit for all stroke deaths and other specified cases, including complications h. Multidisciplinary hospital Stroke PI Committee	
4. Multidisciplinary stroke conferences, continuing education and problem solving to include documented nursing and pre-hospital participation	**D**
5. Feedback regarding stroke patient transfers-out from the ED and in-patient units shall be obtained from receiving facilities	**D**
6. Stroke Registry – data shall be accumulated and downloaded to the receiving agencies	**E**
7. Participation with the regional advisory council's (RAC) PI program, including adherence to regional protocols, review of pre-hospital stroke care, submitting data to the RAC as requested to include such things as summaries of transfer denials and transfers to hospitals outside the RAC.	**E**
8. Times of and reasons for diversion must be documented and reviewed by the Stroke PI program.	**E**
H. REGIONAL STROKE SYSTEM	
1. Must participate in the regional stroke system development per RAC requirements. 2. Participates in the development of RAC transport protocols for stroke patients, including destination and facility capability	**E**
I. TRANSFERS	
1. A process to expedite the transfer of a stroke patient to include such things as written transfer protocols, written/verbal transfer agreements, and a regional stroke transfer plan for patients needing a higher level of care (Comprehensive or Primary Stroke Center)	**E**
2. A system for establishing an appropriate landing zone in close proximity to the hospital (if rotor wing services are available)	**E**
J. PUBLIC EDUCATION/STROKE PREVENTION	
1. A public education program to address: a. Signs and symptoms of a stroke b. Activation of 911 c. Stroke risk factors d. Stroke prevention	**E**
2. Coordination and/or participation in community/RAC stroke prevention activities	**E**
K. TRAINING PROGRAMS	
1. Formal programs in stroke continuing education provided by hospital for staff based on needs identified from the Stroke PI program for: a. Staff physicians b. Nurses c. Allied health personnel, including mid-level providers	**D**